APPLICATION FOR ADJUSTMENT OF CLAIM FOR PROVIDER FEE

State Form 18487 (R3 / 3-02)

File original and 4 copies.

FOR STATE USE ONLY
Application number

INDIANA WORKER'S COMPENSATION BOARD
402 W. Washington St., Rm. W196
Indianapolis, IN 46204-2753

PLAINTIFF vs DEFENDANT

Plaintiff (*provider*)		Defendant (*employer*)
Name of plaintiff (*provider*)		Name of defendant (*employer*)
Address (*number and street*)		Address (*number and street*)
City, state, ZIP code		City, state, ZIP code
Telephone number		Telephone number
Name of attorney (*must complete*)	**vs**	Name of insurance carrier
Address (*number and street*)		Address (*number and street*)
City, state, ZIP code		City, state, ZIP code
Area code		Area code / Telephone number
Attorney number		

Must check one

☐ **Total Billing** (*no payment received*) ☐ **Balance Billing** (*partial payment received*)

THE PLAINTIFF RESPECTFULLY REPRESENTS TO THE BOARD AS FOLLOWS

That the defendants, as employer and employer's compensation insurance carrier, owe and are indebted to the plaintiff on account in the sum of,

_____ dollars for

provider's fee and supplies in the treatment of the injuries for _____

incurred as a result of an injury / illness arising out of and in the course of the employment with the defendant employer,

on the _____ day of _____, 20 _____, in the county

of _____.

Date of service: _____

That said services were rendered as follows: (*check one*)

☐ In an emergency
☐ The employer failed to provide such service
☐ The employee was justified in obtaining such service
☐ Employer or insurance carrier approved such service

Wheretofore the plaintiff prays to the Board to find against the defendant on said account the sum of:

$ _____.

Signature of plaintiff	Date signed (*month, day, year*)

This form cannot be processed unless filled out completely.
Must attach copy of billing.